

An address at the

“Women, Health, and Development:
Perspectives from Israel and Canada”

Conference in Memory of Freda L. Paltiel

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Good afternoon, ladies and gentlemen, and thank you. It is a high honour for me to participate in this most fitting celebration of the life and work of Freda Paltiel. The theme of our conference—“Women, Health and Development”—captures in a phrase the calling to which Freda dedicated her astonishing energies, and her great and generous intelligence.

I was especially touched by your invitation to join you here in Jerusalem today because I have been personally enriched by Freda's company, and by her wisdom.

Freda would, of course, have been the star attraction at a seminar on a topic she loved, in an institution she loved, in a country she loved. It is wonderful that her children have organized this conference in her honour and that the Canadian Friends of the Hebrew University and the Braun School of Public Health have sponsored it.

I am privileged to have the opportunity to be with you. Not all of you will have known Freda Paltiel but many of you will be familiar with her work.

I have known Freda since I was about 21 or 22. We were both doing a graduate course in the sociology of education. She was one of “the Ladies”, i.e., women who seemed significantly older than us who had come back to do (more) graduate work. She worked, had children, was married to an eminent professor of Political Science, Prof. K.Z. Paltiel, who ran a very important Royal Commission on Election Expenses that led to significant changes. Freda was part of a small group of women in the Canadian public service whose interventions in a public policy changed things forever. Elegant in her thinking and presentation, confident in her opinions, not overly impressed by those in power, Freda and her very small team in the Privy Council Office (the Prime Minister's department in Canada) were asked by Prime Minister Pierre Elliott Trudeau to sort the 167 recommendations of the 1970 Royal Commission on the Status of Women into the “do-able now” and the “do-able later”. They shaped the on-going institutional and legislative changes that transformed the possibilities for Canadian women.

She was there at the right time to ensure that the Canada Pension Plan has a “dropout” provision so that benefit accumulation was not damaged by years “dropped out” by women who had children and interrupted their work. She seized the opportunity of unemployment insurance reforms to “add on” maternity (now parental) benefits. And many more. She was often an annoyance to others who didn’t like to be reminded of all that was left to do to make the world a more equitable, less un-balanced place. She could at times be rather grand. But she was a woman who made a difference, who, earlier than most, recognized that work, community, and family was the golden trilogy of our lives that women had much more difficulty balancing. But each element was needed for a full, productive, socially useful life. Freda’s boundaries were never national. Her channels more effective than only the formal. She believed in evidence, analysis, engagement, results. And that is why we are here today.

Freda and I carried on a long conversation about our lives and work that spanned almost forty years — and years could go by between installments. I am not convinced she ever really recognized that I had grown up — but then I never abandoned my deference. Such was the interwoven fabric of our lives.

As scholar, activist and advocate, Freda understood the powerful interactions between knowledge, policy, politics, and human well-being. And nowhere do these connections operate with more force, or more effect, than in the dynamics of gender, inequality and governance in the provision of health care.

In fact, I would argue that the development of a country, and the quality of its government, can in large measure be judged by one simple standard: equity of access to adequate health care. And these dynamics are not just about money and policy. They are about power and politics. Moreover, as I will argue, they are about hard-nosed scholarship and research for action.

My argument here begins with a straightforward observation: Disadvantaged people seldom get the health care they need. That is true whether they are disadvantaged by poverty, or geography, or ethnicity—or by gender. These impediments to access—to equality—are an offence against justice. And they are sources of great human suffering.

But inequalities of health and well-being are also pernicious ingredients of social division, political cleavage and economic loss. Systematic failures of health care provision will always work against sustainable, democratic and peaceful development. Failure to provide fair and sufficient health care delivery is both a symptom and a cause of a country’s failure to approach its full development potential.

It seems plain to me, therefore, that the provision of health care needs to be addressed both as an obligation of equity and as an imperative of good governance. Taken together, the interactions of governance, equity and health can define the character of a state, the justice of a society, and the shared well-being of its people.

This is a truth that applies in every country, rich or poor. But it applies with special urgency in developing countries, not least because preventable disease and death in these countries do so much to deepen poverty, frustrate growth, and aggravate social strife. The terrible damage

inflicted by the AIDS epidemic on development in sub-Saharan Africa serves as a dramatic and horrifying proof of this relationship between human health and development.

In my own organization, the International Development Research Centre, we have committed ourselves to promoting a more thorough and widespread understanding of governance, equity and health. Indeed, we have created a Governance, Equity and Health program initiative, which is supporting some exceptionally rewarding research exactly along these lines.

Let me describe some of our experience in this realm, with three brief examples.

In South Africa, sexual violence remains a plague of tragic and deadly dimensions. But as many others have observed in very different settings, one of the distinguishing features of violence against women is the secrecy of it, and the silence. In almost every society, violence against men is generally the public violence of criminality and political conflict. And public violence falls rather naturally in the domain of public policy. The violence against women is too generally private violence, and too often escapes the notice or the remedies of public policy.

Beginning in 1998, IDRC has been supporting research in South Africa aimed at dispelling the secrecy, by informing effective policies of public education and public engagement. By 2002, rigorous surveys of South African young people had established a baseline of data on sexual violence, HIV risks and public attitudes to these and related issues. The objective has been to increase the capacity of communities, and their confidence, to understand and address their own problems through a direct participation in governance—the kind of participation never possible under apartheid.

As a result, women and young people are becoming empowered—by knowledge—to speak out and take part in making and executing better public policy to protect women against violence. The evidence generated by the research is now informing school curricula all across South Africa.

My second example also happens to come from South Africa, although the lessons of it are applicable throughout the developing world. Respiratory diseases, including tuberculosis, are severe and endemic in many developing countries. Effective prevention and treatment depend entirely on well-functioning primary health care systems. With IDRC support, researchers in South Africa are working directly with nurse practitioners in the field to identify barriers to effective care—and to engage the practitioners directly in devising and implementing better health care programs.

The object here is to foster new collaborations between practitioners and policy-makers for more effective and efficient health care delivery. Given the strong link between HIV/AIDS and lung diseases—and the disproportionate incidence of HIV/AIDS among African women—this is an objective of central importance to improving women's health.

My third example addresses a chronic and common misallocation of health care resources—the misallocation that favours well-off people in cities while disfavouring poor people in rural areas. Equinet—the Network for Equity in Health in Southern Africa—was set up in 1997 to analyze

connections between health and health spending, and between governance, health policy and health outcomes. Its overarching aim is to build capacities in all the countries of Southern Africa to improve equity of access, and effectiveness, in the provision of health care. And it does this by engaging communities directly in researching health conditions, in formulating health policy, and in evaluating policy results.

What all of this experience has taught us—experience in Asia and Latin America as well as in Africa—is that policy and institutional reforms will fail when they are not rooted in the particular realities of a society. More than that, our research shows that improving health and access to care—especially for people disadvantaged by gender or poverty, or by geography or ethnicity or conflict—is always a problem of improving governance. In the end, improving the health and well-being of women requires their full and informed participation in the politics of policy-making.

All of which reinforces my conviction that pragmatic and politically sophisticated research is essential to the design and execution of equitable and effective health policy.

This is research that satisfies three critical objectives in the policy process. First, it is research that strengthens health systems by producing the hard evidence to inform decisions based on the real needs of real people—as those needs are understood by the people themselves.

Second, it is research that promotes civic engagement—genuine collaboration among researchers, NGOs, clinicians, and governments at every level. People are entitled to a voice in health policy decisions—but their voices must be informed to be truly meaningful or effective.

And our third objective for research is to make certain that the research matters—that it answers real policy problems with timely, practical, and affordable solutions. This requires the research community to build long-term relationships with the policy community. But it also requires researchers to exploit the opportunity that crisis sometimes provides, to inform decision-makers with best-guess advice for quick results.

But of course, Freda Paltiel understood these imperatives of governance, equity and health many years ago. She understood the power of knowledge—and demonstrated a keen knowledge of power. She taught us that equity is achieved by informed political action.

But we have a busy agenda today, and I look forward to hearing your thoughts about these universal and pressing questions. Once again, for the opportunity you have given me to honour Freda Paltiel's insight and passion, I thank you.